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Legislative Notice

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S. 1344 – The Patients’ Bill of Rights Act (S. 6)

Calendar No. 200

NOTEWORTHY

- Under a unanimous consent (U.C.) agreement of June 29 governing Senate consideration of patients’ rights legislation, the Majority Leader last week submitted S. 1344, a bill identical to (the start print version of) Senators Daschle and Kennedy’s S. 6, to serve as the underlying bill. S. 1344 is on the Senate Calendar.
- The U.C. provides that S.1344/S. 6 will become the pending business today at 1:00 p.m., with a vote on final passage on Thursday, July 15. The U.C. limits debate on the bill to three hours, equally divided. All amendments must be relevant to the subject of the underlying bill or to health-care tax cuts. The Minority Leader today will offer the initial first-degree amendment, with subsequent first-degree amendments offered in an alternating fashion. Each party is allowed one second-degree amendment per first-degree amendment. Debate on each amendment is limited to 100 minutes, equally divided. No motions to commit or recommit will be in order. The Majority Leader may offer the final amendment, with no second-degrees in order. [The complete text of the U.C. can be found on p. 2 of this Notice.]
- S.1344/S. 6 would regulate the structure and operation of all health insurance products at the federal level; impose mandates on consumers, health insurers and employers; enable new lawsuits against employers and insurers for unlimited compensatory and punitive damages; and increase the number of uninsured Americans by an estimated 1.9 million.
- The Republican “Patients’ Bill of Rights—Plus Act” (S. 300), which may be offered as a substitute amendment, would make health insurance more affordable by (1) accelerating full tax deductibility of health premiums for the self-employed and (2) expanding the medical savings account (MSA) pilot program to all Americans. S. 300 would impose federal regulations primarily on those health plans that states cannot themselves regulate, provide for an independent external appeals process, prevent genetic discrimination, and increase health quality.

HIGHLIGHTS

Unanimous Consent Agreement

On June 29, 1999, the Senate entered into a unanimous consent agreement governing consideration of the debate. That U.C. reads in its entirety:

Ordered, That the Majority Leader, or his designee, introduce the underlying health care bill and that it be placed on the Calendar by 12:00 noon, Thursday, July 8, 1999.

Ordered further, That at 1:00 p.m. on Monday, July 12, 1999, the bill become the pending business, with a vote occurring on final passage at the close of business on Thursday, July 15, 1999.

Ordered further, That debate on the bill be limited to 3 hours, to be equally divided in the usual form; that all amendments in order to the bill be relevant to the subject of amendments numbered 702, 703, the introduced bill, or health care tax cuts; that all first degree amendments be offered in an alternating fashion with the Democratic Leader to offer the initial first degree amendment; that all first and second degree amendments be limited to 100 minutes each, to be equally divided in the usual form; that second degree amendments be limited to 1 second degree amendment per side, per party; that no motions to commit or recommit be in order, or any other act with regard to the amendments be in order; and that just prior to third reading of the bill, it be in order for the Majority Leader, or his designee, to offer a final amendment, with no second degree amendments in order.

Ordered further, That following passage of the bill, should the bill upon passage contain any revenue blue slip matter, the bill remain at the Desk; that when the Senate receives the House companion bill, the Senate proceed to its immediate consideration; that all after the enacting clause be stricken, the text of the Senate-passed bill be inserted in lieu thereof, and the bill, as amended, be passed; and that the Senate insist on its amendment and request a conference with the House, all without any intervening action or debate. (June 29, 1999.)

The Democrats' Bill, S. 1344/S. 6

The "Patients' Bill of Rights Act" (S.1344/S. 6) is a sweeping bill authored by Senators Daschle and Kennedy that would impose numerous and costly mandates on employers, workers and the health insurance industry. The greatest cost of these regulations would be paid by

patients who fall out of the insurance pool due to increased costs, and who are thus denied medical coverage. The most notable – and costly – aspects of S.1344/S. 6 are:

- 1) It regulates all health insurance at the federal level and preempts state laws and regulations.
- 2) It imposes a federal definition of “medical necessity” that would dramatically alter the way managed care operates. Under this provision, health plans would be required to pay for whatever care a provider considers appropriate including, in certain situations, substandard or unnecessary care [see, for example, a letter of April 28, 1999, from Blue Cross Blue Shield of Minnesota Legislative Affairs Director Thomas Lehman to Senator Torricelli, available from RPC].
- 3) It would allow expensive personal injury and wrongful death lawsuits against health plans *and employers*. In a poll, 57 percent of small businesses said they would drop coverage if exposed to the Kennedy bill’s liability provisions (Public Opinion Strategies).

Estimates of the aggregate impact of S.1344/S. 6 have suggested it would (CBO, Barents Group):

- Depress family wages by \$207 per year.
- Eliminate 194,000 jobs.
- Cancel the health coverage of 1.9 million Americans.
- Increase private health insurance premiums by an average of 6.1 percent — above and beyond any increases caused by inflation and other sources.

When families lose their health coverage, they lose the very medical care that S.1344/S. 6 claims it provides.

In contrast, the Republican “Patients’ Bill of Rights—Plus Act” (S. 300, hereinafter referred to as the Republican bill) protects patients and makes health care more affordable.

- According to the Congressional Budget Office, the Republican bill) would increase premiums by less than 1 percent.
- The Republican bill makes health insurance more affordable for the self-employed by letting them deduct 100 percent of their health premiums in 2000 – three years ahead of schedule.

- At the same time, the Republican bill gives patients more control over their medical care and makes health coverage more affordable by expanding access to medical savings accounts (MSAs). More than one-third of those who have availed themselves of the current MSA demonstration plan previously were uninsured.

BACKGROUND

The federal government currently exempts employer-provided health benefits from taxable income which allows workers to receive tax-free medical care — provided workers pay for it through insurance chosen by their employer. Two important consequences of this tax policy have led to today's patients' rights debate.

First, the fact that patients were consuming medical care paid for by a third party led to rising medical inflation, which peaked in the 1980s and early 1990s. Second, employers looking for ways to control costs began to implement various restrictions on the provision of health benefits. These restrictions — known generally as “managed care” — have helped to control costs but have done so by limiting coverage to specified treatment options and providers.

In the 105th Congress, both parties drafted legislation to address the public's concerns with managed care. Because the minority refused several offers to debate the issue on the floor, the 105th Congress adjourned without final action by the Senate.

In January, 1999, members of the Republican Health Care Task Force introduced “The Patients' Bill of Rights Plus Act” (S. 300, referred to the Committee on Finance), while Senators Kennedy and Daschle introduced the “Patients' Bill of Rights Act” (S. 6). Despite similar titles, the two bills reflect different approaches to the role of government in health care and to the assurance of health care quality.

The Kennedy bill is a litany of federal mandates on private health insurance — even those insurance products already regulated by state governments. A quick reading of the bill makes evident its primary constituencies. Exposing health plans and employers to expensive lawsuits will prove lucrative for one of the Democrats' largest financial backers: the trial bar. Provisions restricting certain managed care practices (particularly its costliest requirement, that health plans cover whatever a physician decides is “medically necessary”) are meant to garner support from the medical community. And while the bill would immediately increase the cost of coverage for most Americans, union health plans are exempted for a number of years.

Nonetheless, the Kennedy bill is targeted chiefly to those who want a government take-over of America's health care system. President Clinton, who in 1993-4 failed to impose a

government-run health care system all at once, has urged the Senate to pass patients' rights legislation like that sponsored by Senator Kennedy. He explained his revised strategy last year:

What I tried before won't work. Maybe we can do it in another way. That's what we've tried to do, a step at a time, until we finish this.

Consider why President Clinton might think the Kennedy bill brings us closer to his goal:

- It extends the federal government's power over parts of our health care system traditionally regulated by the states.
- It builds a standard benefits package which all Americans must buy if they want health coverage.
- The estimated 2 million Americans who lose their private health insurance because of the Kennedy bill might find a government-run system more attractive.

As Senator Kennedy stated in 1996, "We're going to get this done, and we're going to keep coming back at it. If we have a big sweep for the Democrats in the House and the Senate, we'll get single-payer [i.e., a national health-care system]." That sweep didn't happen, thus the incremental approach.

Public health is too important to be sacrificed to such a big-government vision. Without health coverage, Americans may be able to get care in an emergency room or through Medicaid. But many of the millions who lose coverage because of the Kennedy bill will be unable to afford simple tests that might spot illness early in its course and thus prolong their lives by years.

In contrast, the Republican bill is a strike against government control of the health-care system. It makes coverage more affordable and puts patients in control of their medical care.

Most important in this respect, the Republican bill expands the current medical savings account (MSA) pilot program to make MSAs available to all Americans, not just to a select few. The federal tax code tells patients they can buy their medical care tax-free, but only through their employer and an insurance company. MSAs give patients the tax benefit *and* greater control over their medical care.

At the same time, MSAs make coverage more affordable. The General Accounting Office reports that more than one-third of participants in the limited MSA pilot program were previously uninsured. The Republican bill removes the limitations that have kept millions of Americans from buying MSAs.

The Republican bill also allows self-employed Americans to deduct the full cost of their health insurance premiums immediately. Under current law, they would have to wait until 2003.

Further responding to concerns about patients' rights, the Republican bill imposes some regulation on health plans. However, the Republican bill does so while respecting the states' responsibility to regulate health insurance and without significantly adding to the cost of health insurance. The Congressional Budget Office estimates the regulatory provisions of the Republican bill would increase premiums by less than 1 percent.

President Clinton is right about one thing. The patients' rights debate offers a choice between "whether some people live or some people die." However the president was mistaken: it is the Kennedy bill that will leave sick patients without medical coverage and the Republican bill that will protect patients.

BILL PROVISIONS

Title I: Health Insurance Bill of Rights

Subtitle A – Access to Care

Regulates the composition of all health insurance products.

Section 101 – Mandated emergency care coverage (premium increase: 0.4 percent). In situations where a "prudent layperson" would call for emergency care, S.1344/S. 6 would require all health insurance products to cover emergency services and post-stabilization care (1) without prior authorization, (2) outside the plan's network, and (3) without charging the patient any more than if they received the care within the network.

Section 102 – Mandated point-of-service option (premium increase: 0.2 percent). All insurers that sell a network-only plan must also sell a product with a "point-of-service" option that allows patients to pay more to see a doctor outside the network.

Section 103 – Regulating choice of providers (cost included in Section 108). All health insurance products must allow enrollees to obtain primary care from any available participating primary care provider, and specialty care from any available participating specialist (unless the plan clearly describes the choice limitations).

Section 104(a) – Regulating access to OB/GYNs (premium increase: 0.1 percent). All health insurance products must allow women to choose an obstetrician/gynecologist as their primary care provider. Further, health insurance products may not require a referral before covering routine gynecological care or pregnancy-related care.

Section 104(b) – Regulating access to specialty care (cost included in Section 108). All health insurance products must cover referrals to specialists for serious conditions if treatment is covered. If no specialists are available within a network, insurers must allow an out-of-network referral and cannot charge patients more for out-of-network referrals. All health insurance products must allow patients with conditions requiring coordination of care (life-threatening, degenerative, or disabling) by a specialist to designate a specialist as his primary care provider. All health insurance products must allow standing referrals to specialists for any condition requiring ongoing specialist care.

Section 105 – Continuity of Care (premium increase: 0.2 percent). For patients in a course of treatment, all health insurers must pay for 90 days of care after a provider leaves a network or an employer ceases to offer a health plan (plus longer periods for pregnancy or terminal illness).

Section 106 – Mandated clinical trial coverage (premium increase: 0.5 percent). All health insurance products must cover participation in clinical trials for patients with life-threatening or serious illnesses for which no standard treatment is effective.

Section 107 – Regulating drug formularies (premium increase: 0.1 percent). Provides that insurers that only cover drugs from an approved list (formulary) must (1) include network physicians and pharmacists in developing of the formulary, (2) disclose any formulary restrictions, and (3) cover off-formulary drugs when necessary. Health insurance products may not deny coverage for a drug therapy approved by the Food and Drug Administration (FDA) on the grounds it is, in the plan's opinion, experimental.

Section 108 – Regulating provider networks (premium increase: 0.2 percent). This section requires network health plans to have a network of providers sufficient to make covered care "available and accessible in a timely manner."

Section 109 – Nondiscrimination in delivery of services (premium increase: 0.1 percent). This section prohibits all health insurers from discriminating against any individual in the delivery of health care services on the basis of "race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment."

Subtitle B – Quality Assurance

Mandates that all health insurers establish quality assurance and improvement programs meeting federal requirements.

Section 112 – Standardized data collection (premium increase: 0.2 percent). All health insurers must collect standardized data on patient demographics and quality outcomes, as specified by the Secretary of Health and Human Services.

Section 113 – Regulating network provider selection (premium increase: < 0.05 percent). All health insurers must detail their criteria for provider participation. Health plans may not refuse participation in a network based on a provider's license.

Section 114 – Mandated drug utilization program (premium increase: < 0.05 percent). All health insurers must monitor patients' drug utilization to promote appropriate use.

Section 115 – Mandated, standardized utilization review (premium increase: 0.1 percent). This section mandates that all health insurers review patients' utilization of benefits in accordance with federal standards. In particular, insurers may not offer financial incentives to reviewers for denying care and must submit "at least a sample" of coverage denials for peer review. Further, the section would write into federal law specific time frames for authorization of coverage. Prior authorization decisions must be made within three days. Authorization for continued or extended health care services must be made in one business day. Retrospective review of care already provided must be completed within 30 days.

Section 116 – Federal health care advisory board (\$15 million/5 years). This section creates a new bureaucracy within the Department of Health and Human Services comprised of the Secretary of HHS, the Secretary of Labor, and 20 political appointees. The board is to provide the president and Congress with information on "trends in health care quality," and to advise Cabinet secretaries on monitoring quality federal health care programs.

Subtitle C: Patient Information

Specifies benefits, access, emergency coverage, prior authorization, grievance and appeals, and other pertinent information which plans and issuers shall provide to participants and beneficiaries at the time of initial coverage, annually, within a reasonable period before or after the date of significant changes, and upon request.

Section 121 – Regulating information provided to patients (premium increase: < 0.05 percent). All health insurance products must provide patients with a list of information on plan aspects specified by federal law, including the local providers' ability to accept new patients. Insurers must provide some types of information to patients upon enrollment, annually thereafter, upon request, and before any significant changes in the plan, while others must be presented only on request. Information must be presented in a uniform manner, as stipulated by the Secretary of HHS.

Section 122 – Patient confidentiality (premium increase: < 0.05 percent). All health insurers that maintain medical records of enrollees must safeguard the privacy of such records, maintain such records in an accurate and timely manner, and provide enrollees timely access to their medical records.

Section 123 – Federally mandated state ombudsmen programs (\$55 million/5years). Authorizes federal grants to states for creation of a Health Insurance Ombudsman to assist

patients in dealing with coverage disputes. The federal government will contract with non-profit organizations to create an ombudsman in states that do not create one themselves.

Subtitle D: Grievances and Appeals Procedures

Section 131 – Grievance process (premium increase: 0.3 percent). Requires all health insurance products to establish a procedure for presenting, documenting, resolving and storing information on patient grievances.

Section 132 – Internal appeals (cost included in section 131). All health insurance products must provide for internal appeals of adverse coverage decisions. The section dictates what constitutes an appealable decision, who may be involved in the appeal, time frames for resolving appeals, and expedited review processes.

Section 133 – External appeals (cost included in section 131). All health insurance products must provide for external appeals of adverse coverage decisions. The section allows states and the administration to require that external appeals be conducted by entities of their designation.

Subtitle E: Protecting the Doctor-Patient Relationship

Section 141 – “Anti-gag” mandate (premium increase: < 0.05 percent). Declares null and void any health plan contract provision that restricts a provider’s ability to discuss a patient’s health, treatment options, or health plan financial incentives that may affect treatment options.

Section 142 – Prohibition of improper incentives (premium increase: < 0.05 percent). Prohibits health plan contracts from transferring to providers any liability for decisions made by the health plan or rewarding providers for decisions regarding specific patients.

Section 143 – Additional regulation of provider networks (premium increase: 0.2 percent). Network health plans must abide by federal guidelines for accepting applications from providers, notifying providers of adverse participation decisions, and allow providers to appeal such decisions.

Section 144 – Protection of patient advocacy (cost included in section 143). Prohibits health plans from retaliating against providers or enrollees who report on a plan’s performance to a regulatory or accrediting body.

Subtitle F: Promoting Good Medical Practice

Section 151 – Federal definition of “medical necessity” (premium increase: 1.9 percent). The most expensive provision of S.1344/S. 6, this section effectively requires health plans to cover the cost of whatever setting or duration of care a physician decides is “medically

necessary.” The bill defines “medical necessity” as whatever is “consistent with generally accepted principles of professional medical practice.”

Section 152 – Mandated breast cancer coverage (premium increase: <0.05 percent). This section would prohibit health plans from limiting hospital stays after a mastectomy to less than 48 hours, or for a lumpectomy or lymph node dissection to less than 24 hours.

Title II: Application of Patient Protection Standards to Group Health Plans and Health Insurance Coverage Under Public Health Service Act

Section 201 – Application to group health plans and group health insurance coverage. This section amends the Public Health Service Act by applying the “Patients’ Bill of Rights Act” to all employer-provided health plans and health insurance coverage.

Section 202 – Application to individual health insurance. Applies patient protection mandates to the individual health insurance market, already regulated by states.

Title III: Amendments to the Employee Retirement Income Security Act of 1974

Section 301 – Application to ERISA plans and insurance coverage (\$190 million/5 years). Section 301 amends the Employee Retirement Income Security Act of 1974 (ERISA) to require each plan and issuer to comply with the patient protection requirements of S.1344/S. 6.

Section 302 – Enabling lawsuits against ERISA plans (premium increase: 1.4 percent). Currently, patients who are denied a benefit by an ERISA plan can file suit for recovery of the cost of the denied benefit and legal expenses. State personal injury and wrongful death suits are preempted by ERISA. Section 302 would remove this preemption.

Title V: Effective Dates; Coordination in Implementation

Section 501 – Application to existing insurance contracts. Applies S.1344/S. 6 to all health plans and health insurance contracts immediately, with the exception of collectively bargained union health plans, which shall remain unaltered until the contract terminates.

ADMINISTRATION POSITION

No Statement of Administration Position on S.1344/S. 6 was available at press time.

COST

The Congressional Budget Office estimates S.1344/S. 6 would increase private health insurance premiums an average of 6.1 percent. The private-sector mandates in S.1344/S. 6 would cost \$55.7 billion over the 2000-2004 period (the costs amount to \$72.2 billion including the cost of expanded liability).

Because S.1344/S. 6 would increase the cost of health coverage, it would divert taxable private income into untaxed health benefits. Thus, CBO estimates S. 6 would reduce federal receipts by \$720 million in 2000 and by \$9.2 billion over the 2000-2004 period. The bill would increase the cost to the government of the Federal Employees' Health Benefits Program by \$420 million over the 2000-2004 period (mandatory spending: \$165 million). Administrative and regulatory oversight of S.1344/S. 6's provisions would cost \$315 million (discretionary) over the next five years.

Private forecasts estimate S.1344/S. 6 would cause 1.8 million (Lewin Group) to 1.9 million (Barents Group) Americans to lose their health coverage. Further, Barents Group estimates indicate S.1344/S. 6 would lower household wages an average of \$207 annually, and would eliminate 194,000 jobs by 2003.

OTHER VIEWS

On June 17, the Committee on Health, Education, Labor & Pensions reported S. 326, a companion to S. 300. Majority and minority views were filed with respect to S. 326. In that report, Democratic Senators expressed support for S. 6 which was defeated in committee, 10-8.

These Senators criticized S. 326 for not applying to all health insurance products and for not including the provisions listed above in S.1344/S. 6.

POSSIBLE AMENDMENTS

As S.1344/S. 6 itself addresses many of the minority's positions, it is expected Democrats may offer some cursory or inconsequential amendments to their own bill merely to highlight the issues already contained therein. Detailed amendment summaries are available from leadership and committee staff. Anticipated from both Republicans and Democrats are:

Kennedy. To highlight applicability of S.1344/S. 6 to both federally and state-regulated health insurance products.

Robb. Mandated ob/gyn coverage.

Democrat. Mandated mastectomy coverage.

Bingaman. Regulating access to specialists.

Dodd. Mandated clinical trial/prescription drug coverage.

Schumer/Kerrey. Independent appeals process.

Durbin. Expanded liability.

Graham. Mandated emergency care coverage.

Feinstein. Federal definition of "medical necessity."

Mikulski. Continuity of care.

Wellstone. Mandate point-of-service.

Wyden. Anti-gag mandate.

Harkin. Provider nondiscrimination.

Lieberman. Information disclosure.

Reed. Ombudsman.

Democrat. Strike medical savings accounts.

Chafee. Alternative bill.

Republican. Full deductibility of health insurance for the self-employed.

Grams. Full deductibility of health insurance for those without employer-sponsored coverage.

Republican. The "Patients' Bill of Rights Plus Act" (S. 300) [summary attached].

Staff contact: Michael F. Cannon, 224-2946
Attachment: Summary of Republicans' S. 300

[For more information, please see the following RPC papers:

"Republicans Protect Patients, Democrats Increase Health Care Costs," 6/22/99;

"AMA Votes to Unionize Doctors: Now More Than Ever, Enact MSAs," 6/25/99;

"Canceling Coverage Protects Nobody: The Cost of 'KennedyCare' (S. 6)," 7/8/99; and

"CBO: The Kennedy Bill (S. 6) Is a \$72 Billion Hidden Tax Increase," 7/9/99.]

Summary of

THE PATIENTS' BILL OF RIGHTS PLUS ACT

"The Patients' Bill of Rights Plus Act" has six major components that will provide consumer protections, enhance health care quality and increase access. These are:

1. Consumer protection standards for the 48 million Americans covered by self-funded group health plans
2. Comparative information about health insurance coverage for the 124 million Americans covered by both self insured and fully insured group health plans
3. New standards for coverage determinations and internal/external appeal rights for 124 million Americans covered by both self insured and fully insured group health plans
4. A ban on the use of predictive genetic information for underwriting purposes for 140 million Americans covered by both self insured and fully insured group health plans and individual plans
5. New quality focus and expanded research activities for the Agency for Health Care Policy and Research
6. Provisions that increase health insurance coverage by allowing full deduction of health insurance for the self-employed, the full availability of medical savings accounts and the carryover of unused benefits from flexible spending accounts.

An equally important goal of "The Patients' Bill of Rights Plus Act" is to provide these new protections without significantly increasing the cost of health coverage and causing more Americans to become uninsured. The CBO estimates that the Act would raise average premiums by about 0.8 percent.

1. Consumer protection standards for self-funded plans:

Since States already regulate insured health plans, the bill provides that the following standards would apply to the 48 million Americans covered by self-funded group health plans governed exclusively by the Employee Retirement and Income Security Act (ERISA).

Emergency Care: Plans would be required to use the "prudent layperson" standard for providing in network and out of network emergency screening exams and stabilization.

Choice of Plans: Plans that offer network-only plans would be required to offer enrollees the option to purchase point-of-service coverage. Small employers with

50 or fewer workers would be exempt. Also exempt would be group health plans that offer two or more options with significantly different providers. Plans could charge higher premiums and cost sharing for the POS option.

OB-GYN/Pediatricians: Health plans would be required to allow direct access to obstetricians/gynecologists and pediatricians for routine care without referrals.

Continuity of Care: Plans who terminate or non renew providers from their networks would be required to notify enrollees and allow continued use of the provider (at the same payment and cost-sharing rates) for up to 90 days if the enrollee is receiving institutional care, or is terminally ill; and, in the case of a pregnancy through post-partum care.

Access to Medication: Health plans that provide prescription drugs through a formulary would be required to ensure the participation of physicians and pharmacists in developing and reviewing that formulary. Plans would also be required to provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate.

Access to Specialists: Health plans would be required to ensure that patients have access to covered specialty care within the network, or, if necessary, through contractual arrangements with specialists outside the network. If the plan requires authorization by a primary care provider, it must provide for an adequate number of referrals to the specialist.

Gag Rules: Plans would be prohibited from including "gag rules" in providers' contracts or restricting providers from communicating with patients about treatment options.

Self-pay for Behavioral Health: Plans that offer behavioral health services would be prohibited from barring a participant from self-paying for behavioral health care services.

2. Comparative Information:

All group health plans would be required to provide a wide range of comparative information about health insurance coverage, such as descriptions of the networks and cost-sharing information to the 124 million Americans covered by both self insured and fully insured group health plans.

3. Grievance and Appeals:

All group health plans would be required to have written grievance procedures and have both an internal and external appeals procedure for the 124 million Americans covered by both self insured and fully insured group health plans.

Time frames: Routine requests would need to be completed within 30 days, and expedited requests for care that could jeopardize enrollee's health would have to be handled within 72 hours.

Qualification of reviewers for Internal/External Appeals: Appeals for coverage determinations based on lack of medical necessity or experimental treatment must be by a provider with appropriate expertise in field of medicine involved.

External Appeals: Enrollees and their authorized providers could appeal to independent external medical reviewers for amounts above a significant financial threshold or where the enrollees' health is in jeopardy for issues based on medical necessity. They may also appeal for services that involve an experimental treatment where the enrollees' health is in jeopardy. External reviewers would include those certified as meeting specific criteria established by the State or Federal government for this purpose. The determination of an independent external review is binding on plans and issuers.

The external reviewer would be required to have relevant expertise and must consider appropriate and available information, including evidence offered by the patient and the patient's physician, expert consensus, peer-reviewed literature, and the plan's evidence-based criteria and clinical practice guidelines.

4. Genetic Information:

All group health plans and health insurance issuers would be prohibited from denying coverage, or adjusting premiums or rates based on "predictive genetic information" for the 140 million Americans covered by both self-insured and fully insured group health plans and individual health insurance plans. The term "predictive genetic information" includes individual's genetic tests, genetic tests of family members, or information about family medical history.

5. Refocusing AHCPH on Quality Improvement:

The bill would refocus AHCPH (and rename it the Agency for Healthcare Research and Quality) to encourage overall improvement of quality in the nation's health care systems. The new agency will facilitate state-of-the-art information systems, support primary care research, conduct technology assessments, and coordinate the Federal Government's own quality improvement efforts.

6. Provisions that would increase access to health insurance

The bill would expand coverage by allowing full deduction of health insurance for the self-employed, provide for the full availability of medical savings accounts and permit the carryover of unused benefits from flexible spending accounts.